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Spinal Puncture Headache

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• *Headache is the commonest complication of spinal puncture. There is no significant difference in the incidence of headache after lumbar puncture, whether or not the puncture is followed by injection of an anesthetic agent. The sequence of events leading to postlumbar puncture headaches is probably (1) decreased volume of cerebrospinal fluid with lowered pressure; (2) increased differential between the pressure of the cerebrospinal fluid and the intracranial venous pressure; (3) dilation of venous structures with increase in brain volume; and (4) production of tension on the pain sensitive areas in the cranium.*

Prevention of postlumbar puncture headache consists largely in attempts to avoid the development of the pressure differential between that of the cerebrospinal fluid and intracranial venous pressure. Treatment consists of analgesics, hydration and attempts to restore normal cerebrospinal fluid pressure.

HEADACHE is probably the most common untoward complication of spinal puncture. August Bier suffered a severe headache following his submission to the first attempt to produce spinal anesthesia in man in 1898. The incidence of headache following spinal puncture seems to vary little whether or not the puncture is followed by the injection of an anesthetic agent. Babcock,[5] in 1913, reported an incidence of headache of 21 per cent in 5,000 cases. Koster and Weintrob,[25] in 1930, reported postspinal puncture headache in 10 per cent of 6,000 patients who received spinal anesthesia. Woodbridge,[43] in 1937, reported a 4 per cent incidence of spinal puncture headache in 1,381 patients. Jennings[21] reported 30.6 per cent in 1939, while Hingson, Ferguson and Palmer,[19] in 1943, reported an incidence of only 1 per cent in 5,150 cases. Although there is wide variation in the reported incidence of headache following spinal puncture, the majority of the recent reports indicate that the incidence is probably between 10 and 20 per cent.[2, 4, 10, 12, 15, 39, 40]

Recently the authors made a study of a series of 515 consecutive cases in which spinal anesthesia was employed, with the idea of determining the incidence of spinal puncture headache. No attempt was made to direct the patient's attention away from the possibility of headache following anesthesia. In fact, each patient was told that headache was a common sequel of spinal puncture. Each was then asked specifically if he did have a headache after operation. Even though the question was "leading," the answers obtained indicated that the incidence was almost the same as that commonly reported. Furthermore, contrary to a previous assumption, early ambulation after operation apparently did not materially increase the number of postspinal puncture headaches. There seemed to be an appreciably greater incidence of postpunc-

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EDITORIALS

New Industrial Fees

AT LONG LAST the Industrial Accident Commission of the State of California has adopted a new schedule of medical and surgical fees for industrial accident cases.

The new schedule will go into effect on October 1 and will provide an increase of something more than 15 per cent over present fees. Translated into terms of dollars, this means that the physicians of California will come about two and a half million dollars a year closer to realizing fair and compensatory fees for treating the thousands of patients who are injured or become ill each year owing to the nature of their employment.

Action by the Industrial Accident Commission in adopting the new schedule came after 17 months of consideration of an application filed by the California Medical Association. The original application asked for fee increases to produce about a 36 per cent increase in aggregate fees. This requested rise was indicated by a comparison of numerous business indices, including the cost of living index, cost of maintaining an office, increases in wages and other factors. The Association believed it had sound reason to ask for this increase in an effort to bring industrial fees into line with fees paid by all other elements of the community.

Before filing of the current application with the Commission, the C.M.A. committee had been met with the official attitude of the Commission that it had no distinct legal authority to promulgate, adopt or maintain a schedule of medical and surgical fees. This decision by the Commission left the C.M.A. in the position of having to negotiate an improved fee schedule with the insurance carriers. Negotiations along this line were undertaken but, as might be expected, the insurance companies were not particularly anxious to agree to a new set of fees that would increase their costs. In this atmosphere, the two-way bargaining dragged.

Early in 1953 the C.M.A. caused a bill to be introduced into the State Legislature to spell out the legal authority of the Industrial Accident Commission to establish a schedule of medical and surgical fees. Labor and insurance interests agreed with the philosophy of this measure, and it was adopted and signed into law. This meant that as of last September the position of the Industrial Accident Commission was clearly defined; the Commission did have the authority which it felt it had previously lacked.

The new law provided that the Commission must hold public hearings before adopting a medical fee schedule. Such hearings were arranged, all interested parties were notified and three public hearings were held. The California Medical Association went into these sessions in mutual agreement with the insurance industry. Months of meetings had finally produced a schedule which the insurance negotiating committee had approved. The estimated increase in cost to insurance companies was approximately 19.1 per cent.

Then, when the sessions began, employer representatives questioned the percentage of increase requested. In addition, certain labor elements threw up a smoke screen by insisting that each individual item changed in the new fee schedule be justified by the Medical Association. These two elements caused the negotiations to be prolonged and difficult.

Now that the Industrial Accident Commission has taken official action, as of next October 1 all industrial injury cases will be handled on the basis of the new fee schedule.

Before the effective date of the new schedule, the C.M.A. will distribute copies of the fees to all its members. The insurance industry will circularize its members with copies of the schedule. These mailings should go far toward eliminating some of the mis-

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NOTICES & REPORTS

Cancer of the Female Genital Tract

Recommendations of the Cancer Commission of the California Medical Association

THE MOST COMMON CANCER of the female genital tract is cancer of the cervix of the uterus. For practical clinical purposes, this is regarded as an accessible cancer and, when properly treated, should yield approximately 40 per cent five-year clinical cures in an unselected group of patients reporting for treatment. If the condition is diagnosed when it is confined strictly to the cervix, the five-year clinical cure rate is approximately 90 per cent. This form of cancer is therefore a curable form and the responsibility of the medical profession correspondingly great.

The Cancer Commission of the California Medical Association issued its first recommendations on the diagnosis and treatment of cancer of the female genital tract in 1936,[1] and a new edition of these studies was published in 1950.[2] In both studies it was stressed that the vast majority of cases of cancer of the cervix should be treated primarily by radiation therapy. Only in the earliest cases should operation be considered in primary treatment. Since many apparently early or small lesions have already spread to surrounding tissues or produced metastases, many experienced physicians treat *all lesions* by radiation therapy as a primary step.

In the 1950 edition, the Editorial Committee for the Cancer Commission stressed that, "Radiation therapy remains the treatment of choice in practically all cases of cancer of the cervix."

In 1954, the American Cancer Society, National Division, New York City, published monograph No. 8, "Cancer of the Female Genital Tract." There are many excellent diagnostic sections in this monograph. However, the sections on treatment represent opinions so at variance with those of the Cancer Commission and those published in the two editions of Cancer Commission Studies, that the Commission wishes to bring to the attention of all physicians practicing in California its considered opinion that the therapeutic recommendations issued in this monograph should *not* be followed by physicians practicing in this state. Some specific comments on the treatment divisions of the monograph are as follows:

Cancer of the Cervix. The monograph states that "If the lesion is small and the patient young, that is less than 35 years, irradiation is not employed." Comment: The term "small" has no scientific connotation. It may apply to cervical lesions classifiable as Stage II, III or IV. Under average conditions of practice, competent radiotherapy gives superior cure rates to radical operation even in Stage I lesions of the cervix. Therefore, the Cancer Commission still recommends radiotherapy as the primary treatment in the vast majority of cases.

The monograph says further: "Visibly ulcerated lesions, be they Stage I, II, III or IV, should first be treated by radiation . . . When the local lesion has healed, and the patient is convalescent, the further treatment is considered . . . A fair number of patients with Stage I lesions and some with Stage II who are treated by radical hysterectomy will be found to be in good general health . . ." The Com-